SERFF Tracking Number:
 GPML-126557922
 State:
 Arkansas

 Filing Company:
 Government Personnel Mutual Life Insurance
 State Tracking Number:
 45490

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

## Filing at a Glance

Company: Government Personnel Mutual Life Insurance Company

Product Name: SM4/ADB/CIR applications SERFF Tr Num: GPML-126557922 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved- State Tr Num: 45490

Closed

Sub-TOI: L07I.101 Fixed/Indeterminate Co Tr Num: 590 ADB10 State Status: Approved-Closed

Premium - Single Life

Filing Type: Form Reviewer(s): Linda Bird

Authors: Linda Boydston, Norma

Castillo

Date Submitted: 04/22/2010 Disposition Status: Approved-

Closed

Disposition Date: 04/26/2010

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

#### **General Information**

Project Name: SM4/ADB/CIR applications

Status of Filing in Domicile: Authorized

Project Number: SM4/ADB/CIR applications

Date Approved in Domicile: 03/22/2010

Requested Filing Mode: Review & Approval Domicile Status Comments: Forms approved in

the domicile state of Texas.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Market Type: Individual

Group Market Size:

Group Market Type:

Filing Status Changed: 04/26/2010 Explanation for Other Group Market Type:

State Status Changed: 04/26/2010

Deemer Date: Created By: Norma Castillo

Submitted By: Linda Boydston Corresponding Filing Tracking Number:

Filing Description:

This filing contains no unusual or controversial items from normal company or industry standards.

Forms 59O ADB10, 59P CIR10 and SM4CIRA10 described below will be used with the state approved Simplified Issue Whole Life Insurance Policy form (series 58K SIW06).

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

 $\it Life$ 

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

59O ADB10 - Accidental Death Benefit Rider - The accidental death benefit is a supplemental benefit attached to the base policy which pays a death benefit when the death results from accidental bodily injury which results from an accident independent of disease or bodily infirmity. The benefit runs through attained age 70. Issue Ages: 20-60. Benefit amounts: \$3,000-\$35,000. Basis of Values: 2001 CSO Mortality Table, Age Last Birthday, Male, Unismoker combined with the 1959 Accidental Death Benefit Table. Reserves are based on the CRVM method. Continuous functions using an interest rate equal to the maximum allowable valuation interest rate in the Standard Valuation Law.

59P CIR10 - Child Insurance Rider - This rider provides a term death benefit in an amount of \$1,000 per unit on an insured child. Coverage goes to the child's age 25 or to the earlier Expiry Date(no death benefit until the child is 14 days old). It is convertible at the Insured Child's age 25 to 5 times insured. It can be issued on male/female. Issue ages: 15 days to 17 years inclusive. Benefit amount: \$5,000. No Cash Values are provided on this rider. Reserves are based on 2001 CSO Standard Mortality Table with interest at 4.0%. Reserves are calculated for term to age 25 using CRVM with continuous functions.

SM4CIRA10 - Child Insurance Rider Supplemental Application. Form pertains to the Child Insurance Rider. It will be considered as part of the Application for Life Insurance - Part 1 forms described later in this filing description. When used it will be attached and made a part of the policy.

Actuarial Memorandums are included in the filing. Appropriate information regarding (1) effective dates, (2) amount of these riders, (3) premiums, and (4)termination dates will be printed by computer on page 3 (Schedule Page) of the Simplified Issue Whole Life Policy. Specimen Schedule Pages are included. Forms are a new submission. They have not previously been disapproved. They are not intended to supersede a form previously submitted but not yet approved.

Application forms SM45MAR10 and SM420AR10 will be used with both the state approved Simplified Issue Whole Life Insurance Policy forms (series 58K SIW06) and the Graded Death Benefit Whole Life Insurance Policy form (series 58J GDB06), approved in your jurisdiction on 11/01/2006.

SM420AR10 - Application for Life Insurance - Part 1. This application will be used for issue ages 20-49.

SM45MAR10 - Application for Life Insurance - Part 1. This application will be used for issue ages 50-85.

These forms will replace the previously approved application forms (SM420AR,SM450AR), approved in your jurisdiction 11/01/2006. The differences between the previously approved application forms and the ones being submitted in this filing have been highlighted and attached under the Supporting Documentation Tab.

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

These forms are in final print format; however we reserve the right to change the format of the forms due to technological advances.

## **Company and Contact**

#### **Filing Contact Information**

Norma Castillo, Regulatory Filing Assistant anc@gpmlife.com

2211 N.E. Loop 410 800-938-4765 [Phone] 2724 [Ext]

P.O. Box 659567 210-357-6722 [FAX]

San Antonio, TX 78217

#### **Filing Company Information**

Government Personnel Mutual Life Insurance CoCode: 63967 State of Domicile: Texas

Company

2211 N.E. Loop 410 Group Code: Company Type: LAH
P.O. Box 659567 Group Name: State ID Number:

San Antonio, TX 78217 FEIN Number: 74-0651020

(800) 938-4765 ext. 2814[Phone]

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## **Filing Fees**

Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? Yes

Fee Explanation: \$50.00 per form filed separately from policy x 5 forms = \$250.00

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Government Personnel Mutual Life Insurance \$250.00 04/22/2010 35885146

Company

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

## **Correspondence Summary**

#### **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	04/26/2010	04/26/2010

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Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

## **Disposition**

Disposition Date: 04/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

Schedule	Schedule Item	Schedule Item Status Public	c Access
Supporting Document	Flesch Certification	Yes	
Supporting Document	Application	Yes	
Supporting Document	Life & Annuity - Acturial Memo	No	
Supporting Document	Red Line Version	Yes	
Supporting Document	Sample SPCB	Yes	
Supporting Document	Sample Schedule Page 3	Yes	
Form	Accidental Death Benefit Rider	Yes	
Form	Child Insurance Rider	Yes	
Form	Life Insurance Application - Part 1	Yes	
Form	Life Insurance Application - Part 1	Yes	
Form	Part 2 - Child Insurance Rider	Yes	
	Supplemental Application		

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

### **Form Schedule**

Lead Form Number: 590 ADB10

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	59O ADB10	Policy/Cont Accidental Death ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.300	59O ADB10.pdf
	59P CIR10	Policy/Cont Child Insurance ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		60.200	59P CIR10.pdf
	SM420AR1	Application/Life Insurance Enrollment Application - Part Form	Initial 1		59.000	SM420AR10. pdf
	SM45MAR 10	Application/Life Insurance Enrollment Application - Part Form	Initial 1		59.000	SM45MAR10. pdf
	SM4 CIRA10	Application/Part 2 - Child Enrollment Insurance Rider Form Supplemental Application	Initial		59.000	SM4CIRA10- Final.pdf

#### ACCIDENTAL DEATH BENEFIT RIDER

#### General Provisions and Definitions.

This rider gives added benefits, and is part of the Policy to which it is attached.

Consideration for it is the application and payment of premiums shown on the Schedule Page of this Policy.

The date this rider takes effect is the Policy Date, or other date shown on the amended Schedule Page of the Policy, if added after the Policy is issued.

We, Us, Our - Means Government Personnel Mutual Life Insurance Company (GPM).

You, Your - Means the Owner of this Policy.

He, His, Him - Means persons of either sex.

#### What Do We Mean By Accidental Death?

- **A1** Payment under this rider will be subject to the terms of the Policy and this rider. We will pay the amount of Accidental Death Benefit as part of the Policy's death benefit Proceeds if We receive due proof that:
  - 1) Insured's resulted The death from accidental bodily in jury which is the direct of accident result an occurring before the Insured's 70th birthday, independent of disease or bodily infirmity or any other cause and while this rider is in force.

We reserve the right to obtain, at Our expense, an autopsy, unless prohibited by law.

#### Additional Indemnity Benefits.

- **A2** There are additional death benefits if accidental death occurs during one of these two events:
  - a) Accidental death occurred while the Insured was riding as a fare-paying passenger on a public conveyance;
  - b) Accidental death occurred while the Insured was wearing a seat belt or the Insured was riding in a seat protected by an air bag.

#### Some Risks Are Not Covered.

- **A3** We will not pay this benefit if the Insured dies before His first birthday. Nor will We pay if:
- Death of the Insured is contributed to or caused by any attempt at suicide, or intentionally self-inflicted in jury, while sane or insane.
- Death of the Insured is contributed to or caused by disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity.
- Death of the Insured is contributed to or caused by an infection not occurring as a direct result or consequence of the accidental bodily in jury.
- 4(a) The Insured receives in juries while He was committing a felony or trying to commit one, or while resisting arrest.
- 4(b) Death of the Insured is contributed to or caused by participation in an illegal occupation or activity.
- 4(c) Death of the Insured occurs while the proposed Insured is incarcerated.
- 5(a) Death of the Insured is contributed to or caused by travel in or descent from an aircraft, if the Insured acted in a capacity other than as a passenger.
- 5(b) Death of the Insured is contributed to or caused by travel in an aircraft or device used for testing or experimental purposes, used for travel beyond the earth's atmosphere.
- Injuries resulting from war, declared or not, or any act or war or aggression, insurrection, or riot.
- 7) Death of the Insured is contributed to or caused by:
  - (a) The Insured's voluntarily being intoxicated, as defined by the jurisdiction where the accident occurred, or under the influence of any drug unless prescribed or administered by a physician and taken in accordance with the physician's instructions;
  - (b) Poison, gas or fumes, unless a direct result of an occupational accident.

590 ADB10 PAGE ONE

#### ACCIDENTAL DEATH BENEFIT RIDER - Continued

- 8(a) Death of the Insured is contributed to or caused by riding or driving an air, land or water vehicle in a race, speed or endurance contest.
- 8(b) Death of the Insured is contributed to or caused by bungee jumping;
- 8(c) Death of the Insured is contributed to or caused by rock or mountain climbing; and/or
- 8(d) Death of the Insured is contributed to or caused by aeronautics (hang-gliding, skydiving, parachuting, ultralight flight, soaring, ballooning and parasailing).
- 9) In juries or disease which occur while this rider was not in force, or while the Policy remained in force under any of its Nonforfeiture terms, except disability that results from in jury or disease existing at the time this rider was issued if such in jury or disease was disclosed in the application.

#### How and When Benefits Cease.

#### **A4** This rider will terminate:

- At the Insured's 70th birthday, or when the Policy is surrendered or expires, if earlier; or
- If You do not pay the premium for the Policy or this rider before the end of the grace period; or
- 3) If the Policy is continued under its Nonforfeiture terms; or
- 4) If You write Us to drop this rider.

Termination shall not prejudice the payment of benefits for any accident that occurred while the form was in force.

#### Can You Continue this Rider?

**A5** If the Policy is exchanged, converted or renewed, this rider may be continued in force by the timely payment of premiums. This right is subject to the following limits:

- This rider may not exceed the lesser of these:
  - a) Its original value; or
  - b) The Sum Insured under the new Policy.
- This rider must be available for the new Policy under Our published rules when You ask to change the Policy.
- This rider will not be in force longer than the new Policy.

#### Our Right To Contest is Limited.

A6 We cannot contest this rider as to statements made in the application for it after it has been in force during the lifetime of the Insured for two (2) years from its effective date, except for fraud, when permitted by applicable law in the state where the Policy is delivered and/or non-payment of premiums.

If this rider is reinstated, We cannot contest the reinstatement after this rider is again in force during the lifetime of the Insured for two (2) years from the effective date of reinstatement except for fraud, when permitted by applicable law in the state where the Policy is delivered and/or non-payment of premiums.

We will rely on material representations made in the reinstatement application.

#### **Nonforfeiture Values**

**A7** This benefit rider does not have cash values or loan values.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

(Referred to above as GPM)

C. Alan Ferguson Secretary

590 ADB10 PAGE TWO

#### CHILD INSURANCE RIDER

#### General Provisions and Definitions.

This rider gives added benefits, and is part of the Policy to which it is attached.

Consideration for it is the application and payment of premiums shown on the Schedule Page.

The date this rider takes effect is the Policy Date, or other date shown on the amended Schedule Page, if added after the Policy is issued.

We, Us, Our - means Government Personnel Mutual Life Insurance Company (GPM).

You, Your - means the Owner of this Policy.

**He, His, Him** - will be taken to mean persons of either sex.

**Age** - means at any Policy Anniversary, the Age of the Insured Child under this rider at such Insured Child's last birthday. Age is sometimes called Attained Age.

Insured Child - means the Insured's child(ren), stepchild(ren), adopted child(ren), or grandchild(ren) named on the Schedule Page of the Policy to which this rider is attached. Such Insured Child(ren) must live in such Insured's household at the time of application and be over the age of 14 days and under the age of 18 years. Insured Child is sometimes called Insured Children.

#### What Are the Benefits under this Rider?

C1 This rider provides certain benefits upon death of an Insured Child.

For a benefit to be payable, this rider must be in force on the Insured Child when their death occurs and while coverage is in force.

#### Death of an Insured Child.

C2 Upon receipt of proof of death of the Insured Child and due proof of the right of the beneficiary to the Proceeds of this rider, We will pay a death benefit in the amount of the Initial Sum Insured shown under this rider on the Policy's Schedule Page for the deceased Insured Child.

Payment will be made in this order:

- (1) To the Insured, if living; otherwise,
- (2) To the estate of the Insured Child upon whose death payment is being made.

C3 For payment to be made, death must occur:

- Before the Insured Child's 25th birthday; and
- (2) While this rider is in force on such Insured Child.

## Can the Insurance Under this Rider be Converted?

**C4** The insurance on each Insured Child expiring at His Age 25 may be converted as of such expiry date. These terms and conditions apply:

- (1) This rider must be in force for the Insured Child upon His Age 25.
- (2) The Policy to which this rider is attached to must be on premium paying status.
- (3) The amount of the new Policy cannot exceed five (5) times the Initial Sum Insured under this rider.
- (4) Proper written request for conversion must be made and the required premium paid not later than thirty-one (31) days following such expiry date.

Such Conversion will not require evidence of insurability.

C5 Any insurance so converted will be issued at the Age 25 of the Insured Child who is converting coverage. The premium on the new Policy will be the standard class premium then charged by Us. Conversions may be made only to a policy with level death benefits insuring one life on a simplified issue whole life plan in use by Us on the date of the new policy. It shall be subject to amount and other limits in effect at that time. We must consent to adding any accidental death provisions to the new Policy.

#### Who is the Owner of this Rider?

**C6** The Owner of the Policy will be the Owner of this rider. If the Insured is not the Owner, and the Owner dies without naming a contingent owner, ownership shall pass to the Insured.

59P CIR10 PAGE ONE

#### **CHILD INSURANCE RIDER - Continued**

#### Our Right to Contest is Limited.

**C7** We cannot contest coverage on an Insured Child after it has been in force during the lifetime of the Insured Child for two (2) years from its effective date, except for fraud, when permitted by applicable law in the state where the Policy is delivered and/or non-payment of premiums. We cannot contest the reinstatement of an Insured Child's coverage after it has again been in force during the lifetime of the Insured Child for two (2) years from its effective date of reinstatement, except for fraud, when permitted by applicable law in the state where the Policy is delivered, and/or non-payment of premiums. We will rely on material representations made in the reinstatement application.

#### Does Suicide Make A Difference?

C8 If within two (2) years from the effective date of coverage on an Insured Child, such child commits suicide, while sane or insane, We will refund the premiums paid for that Insured Child, and such child's coverage under this rider will then terminate. If applicable, coverage will continue under this rider for remaining living Insured Children as described in this rider.

If the Insured commits suicide as defined in the Policy's Suicide Provision, We will include a refund of premiums paid for this rider in the amount paid under the Policy's Suicide Provision.

#### What Happens if Age is Misstated?

**C9** We will adjust the amount payable if the Age of the Insured Child is misstated. The amount will be that which the premiums would have bought at the correct Age.

#### Can this Rider Be Reinstated?

**C10** this rider can be reinstated if it lapses. We require that You furnish evidence of insurability satisfactory to Us as to all persons upon whose lives insurance will be reinstated. Reinstatement shall then be effective only on those surviving and otherwise insurable. The rules of reinstatement in the Policy apply.

#### How and When Benefits Cease.

**C11** This rider will terminate for each Insured Child:

- (1) Upon His Age 25, or when the Policy is surrendered or expires, if earlier; or
- (2) If You do not pay the premium for the Policy and each Insured Child, before the end of the grace period; or
- (3) If the Policy is continued under its Nonforfeiture terms; or
- (4) If You write Us to drop this rider. If multiple Insured Children are present, the names of each Insured Child must be included in the written correspondence.
- (5) Upon the death of the Insured, any unearned premiums for this rider will be refunded.

#### **Nonforfeiture Values**

C12 This benefit rider does not have cash values or loan values.

### GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

(Referred to above as GPM)

C. Alan Ferguson Secretary

59P CIR10 PAGE TWO

APPLICATION FOR LIFE INSURANCE - Part 1
GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")
2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222
www.gpmlife.com For Ages 20 through 49, Age Last Birthday

Mail Policy to:
□ Agent
Policyholder

1.Name of Proposed Insured (First, M.I., Last)									
2. Sex ☐ Male ☐ Female 3.Birthdate					.Birthplace				
5. US Citizen ☐ Yes ☐ No 6.Social Security #					. Height		Veight		
9. Home Address of Proposed Insured City	5	State	/Country	Z	ip	Tele	ephone Number	ſ	
Best time to call A.M P.M.				Eastern	□ Central		n 🖵 Pacific		
10. Policy: ☐ SECURE-Mark 4 - WL ☐ SECURE-Mark 4 - G	DB  1	11. Aı	mount Applied	for:\$		12. Premium A	mount: \$		
(WL Only) 🗖 Accidental Death Benefit - ADB	1	13. P	remium Mode [	■ Annua		14. Automatic I	Premium Loan		
(WL Only) 🗖 \$5,000 Child Insurance Rider - CIR (Part 2 Requir	ed)		<b>⊇</b> SemiAnnual	■ Mont	hlv EFT	(if available) □	l Yes □ N	0	
15. Beneficiary	So					,		ation	)
Primary						'	'		
Contingent									
17. Owner/Applicant, if other than the Proposed Insured:									
Name Social Security #			Relations	ship to Pr	oposed Insu	red	DOB		
Address:									
18. Physician(s) name, address and phone number:									
19. a. List Life insurance in force on Proposed Insured: Company						r			
b. Will the policy applied for replace or change any existing life				act in any	company?		☐ Yes ☐ N		
20. Has the Proposed Insured used tobacco in any form in the pa							☐ Yes ☐ N		
If questions 21 through 28 are correctly answered "No", th Death Benefit).	e Pro	pose	ed Insured ma	y be elig	ible for SE(	CURE-Mark 4 -	- WL (Whole I	₋ife, F	Full
21. a. Is the Proposed Insured currently hospitalized, confined to a	YES	NO	Circle ea	ach con	dition res	sulting in a '	'Yes" answ	er fo	r
nursing home or hospice, receiving or been recommended						26 through			
to receive home health care, kidney dialysis, or oxygen?			26. During the	past 12	months, has	the Proposed I	nsured:	YES	NO
b. Has the Proposed Insured ever been diagnosed by a physician						ed in a hospita			
as having Congestive Heart Failure or Cardiomyopathy or						······································			
been told (s)he has less than 12 months to live?						ofessional that			
22. In the past 10 years, has the Proposed Insured been						, hospitalizatio			
diagnosed by or received treatment from a member of the						peen completed			
medical profession for Acquired Immune Deficiency Syndrome						acility or receive			
(AIDS); AIDS Related Complex (ARC); or tested positive for					•				
the Human Immunodeficiency Virus (HIV), or the antibodies to						s the Proposed			
such virus?						ce by a medica			
23. Does the Proposed Insured need any assistance performing						ns or surgery fo			
activities of daily living (ADLs) such as eating, bathing, using						al disorder, Maj			
the toilet, independently dressing, taking medications, or						Bipolar Diso			
walking independently without the use of supportive devices?									
24. During the past 24 months, has the Proposed Insured been			' '			ged heart, or a		. —	
treated or given medical advice by a medical professional,									
including office visits, medications or surgery for:						onary Disease			_
a. Stroke, transient ischemic attack (TIA), heart attack, angina,						order (excludin			
or any procedure to improve circulation to the heart or						use)?			
brain?						ystrophy, Mult			
b. Organ transplant or recommendation to have an organ						(ALS) or other	•		
transplant?									
c. Melanoma, internal cancer, or leukemia?						n other than ins			
d. Alzheimer's disease, dementia, Amyotropic Lateral Sclerosis					0	as the Propose			_
(ALS), or Parkinson's Disease?						r's license or h			
e. Emphysema, liver disease, kidney disease, or kidney									
failure?				nations: .				_	_
f. Alcohol and/or drug abuse?									
g. Diabetes requiring insulin or any diabetic complications									
including diabetic kidney disease, eye disorder, numbness in									
hands or feet, diabetic coma, insulin shock, or uncontrolled			I						
hland account		_							
blood sugars?									
blood sugars?									

For Home Office Endorsements:		Special Inst	ructions/Requests:			
AGREEMENT: I have read this appli information given in it is true, complete, condition of the Proposed Insured that the contestable period. It is agreed that	and correctly wr are material to t	itten. I understan	d that any missta	atements as to th	ne health	or physical
A. This application, Part 2 of this application Life as the basis of any policy which equivalent to the original.						
B. Acceptance of a policy issued on this Endorsements." Written consent must						Home Office
C. Any policy issued by GPM Life, or is delivered to the owner during the application continue to be true and material change in health or other ris	lifetime of the complete. The lisk factors taking	Proposed Insured Proposed Insured place before policy	d, and all the sta I and Owner/App cy delivery.	atements and a plicant must noti	nswers ( ify GPM	given in the Life of any
D. NO AGENT, BROKER OR MEDICAL TO MAKE OR MODIFY CONTRACTS ONLY AN AUTHORIZED OFFICER (	S, OR TO WAIVE	ANY OF GPM LI	FE'S RIGHTS, C			
BACKUP WITHHOLDING CERTIFICA proposed owner) certify that (A) my So and (B) I am not subject to backup with withholding as a result of failure to repo withholding. (NOTE: You must cross of backup withholding.)	ocial Security (Ta holding either be rt interest or divid	axpayer Identifica ecause I have not dends, or the IRS	tion) number as been notified by has notified me the	shown in the Ap the IRS that I ar nat I am no longe	pplication n subjec er subjec	is correct, to backup to backup
AUTHORIZATION TO OBTAIN AND D	1001 005 11150			1 00 1		
health facility, facility for the treatment related facility, employer, insurer, or it enforcement unit, consumer reporting a physical health, occupation, avocation, information to GPM Life or its reinsure MIB, to give such information to any information obtained will be used to de Life to its reinsurer(s), the MIB, or other my application or claim, or as may be original. I also agree that this form will issuance, reinstatement, or change of a authorized to act for me, may obtain a "Medical Information Bureau, Inc." from WARNING: Any person who knowing	as agent, reinsuragency, or other other insurance r(s) at any time, agent or insurar termine eligibilities persons or or otherwise lawfully be valid for (1) an insurance policopy of this form GPM Life.  Telegipa and with the	rer, the Medical insurance support, character, habits including after make support organy for insurance conganizations perfort required. I agree 24 months from the ficy, or (2) the durant. I acknowledge intent to defrate	Information Bure torganization hat a, driving record, by death. I further nization acting for overage and benefit to a photocophe date signed in the date signed in the date of a claim for receipt of notices and any insurance.	au, Inc. (MIB), ving information finances, or age r authorize all sar GPM Life or iterits, and may be or legal services by of this form with connection with the benefits. I known entitled "Informatical ecompany, or estimation of the company, or estimation of the company of th	governm as to th of me, t aid source ts reinsumer release in connumer in connu	nent or law e mental or o give such ces, except urer(s). Any ed by GPM nection with valid as the plication for or a person actices" and
an application for insurance or sett purpose of misleading, information of a crime and subjects such person to	lement of claim oncerning any f	containing any fact material ther	materially false	information or	conce	als, for the
Proposed Insured's Signature		Date	City & State Where	Application Comple	ted	
X Owner's/Applicant's Signature (If other than Pro X	oposed Insured)	Date	City & State Where	Application Comple	ted	
AGENT'S STATEMENT: I HEREBY C complete and true to the best of my known Insured which is not fully set forth here to the application being signed; that the lnc. were given to the Proposed Insu witnessed the above signature(s):	owledge and beli in; that I carefull e Special Notices red. I further ce	ef; that I know of I ly asked each quo s regarding Inform rtify that I have i	no condition affect estion as written nation Practices a	cting the insurabi before recording and the Medical I	ility of the g each a informati	e Proposed nswer prior ion Bureau,
To the best of your knowledge:			(INEQUINED)	Y	es	No
A. Has the Proposed Insured any exist						
B. Is the insurance applied for intended or annuity policy or contract? If the answer to A or B is "Yes", attact	-				_	
	п сотпрієтей тер	nacement ionns II	required by your	sialt.		
Writing Agent's Signature	Data	Agont's Nama (Diago		State / License #	CDMI	To Agent #
Writing Agent's Signature	Date	Agent's Name (Pleas	se Pilill)	State / License #	GPIVI LIT	e Agent #

	RECEIPT FOR PAYMENT					
Received from	Date					
the sum of \$	The payment is received subject to the conditions below. This receipt does not provide any insurance.					
I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.						
Signature of Writin	ng Agent					
ALL CHECK	S MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY					
application, if paid by c take effect until the full the effective date of the and complete. The Pro	This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not ake effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other isk factors taking place before policy delivery.					
risk factors taking place before policy delivery.  NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY.  TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS.  ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.						

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

#### GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

APPLICATION FOR LIFE INSURANCE - Part 1
GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")
2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222
www.gpmlife.com For Ages 50 through 85, Age Last Birthday

Mail Policy to:
□ Agent
Policyholder

1.Name of Proposed Insured (First, M.I., Last)					
2. Sex ☐ Male ☐ Female 3.Birthdate			4.Birthplace		
5. US Citizen ☐ Yes ☐ No 6.Social Security #			7. Height 8. Weight		
9. Home Address of Proposed Insured City	S	State/0	Country Zip Telephone Number		
Best time to call A.M P.M.		Tim	e Zone: 🗖 Eastern 🗖 Central 🗖 Mountain 📮 Pacific		_
10. Policy: SECURE-Mark 4 - WL SECURE-Mark 4 - GI	DB  1	11. An	nount Applied for:\$   12. Premium Amount: \$		
☐ SECURE-Mark 4 - MBWL (WL Only) ☐ Accidental Death Benefit - ADB	1	13. Pr	emium Mode  Annual  14. Automatic Premium Loan		
(WL Only) (WL On			I SemiAnnual 🔲 Monthly EFT (if available) 🖵 Yes 🗀 No	0	
15. Beneficiary		ocial S	Relationship 16. Proposed Insured's Occup	ation	
Primary					
Contingent					
17. Owner/Applicant, if other than the Proposed Insured:					
Name Social Security #			Relationship to Proposed Insured DOB		
Address:					
18. Physician(s) name, address and phone number:					
19. a. List Life insurance in force on Proposed Insured: Company					
b. Will the policy applied for replace or change any existing life					
20. Has the Proposed Insured used tobacco in any form in the pa	st 12	mont	hs?	10	
If questions 21 through 29 are correctly answered "No", the Death Benefit).	e Pro	pose	d Insured may be eligible for SECURE-Mark 4 - WL (Whole L	.ite, F	ull
	YFS	NO.		YES	NO
21. Is the Proposed Insured currently hospitalized, confined to a		, ,,,	28. During the past 24 months, has the Proposed Insured been		
nursing home or hospice, receiving or been recommended			treated or given medical advice by a medical professional,		
to receive home health care or kidney dialysis, or been			including office visits, medications or surgery for:		
diagnosed by a physician as having Alzheimer's Disease,			a. Stroke, transient ischemic attack (TIA), heart attack,		
dementia, or Amyotropic Lateral Sclerosis (ALS) or been told			angina, or any procedure to improve circulation to the		
(s)he have less than 12 months to live?			heart or brain?		
22. In the past 10 years, has the Proposed Insured been			b. Organ transplant, or recommendation to have an organ		
diagnosed by or received treatment from a member of	:		transplant?		
the medical profession for Acquired Immune Deficiency	•		c. Melanoma, internal cancer, or leukemia?		
Syndrome (AIDS); AIDS Related Complex (ARC); or tested			d. Parkinson's Disease, seizure, neurological disorder, Major		
positive for the Human Immunodeficiency Virus (HIV), or the			Depression, Schizophrenia, Psychosis, Bipolar Disorder,		
antibodies to such virus?			or other psychiatric disorder?		
23. During the past 5 years, has the Proposed Insured been			e. Liver disease, kidney disease, kidney failure, Lupus (SLE)	_	_
convicted of a felony, been incarcerated, or been on parole or			or Amyotropic Lateral Sclerosis (ALS)?		
probation for any offense?			f. Irregular heart rhythm, enlarged heart, or any other heart		
24. Is the Proposed Insured currently receiving or been			disorder?		
recommended to receive oxygen?	ш		g. Alcohol and/or drug abuse?h. Diabetes requiring more than 80 units of insulin, or any	ч	
as having Congestive Heart Failure or cardiomyopathy?			diabetic complications, including diabetic kidney disease,		
26. Does the Proposed Insured need any assistance performing	_	_	eye disorder, numbness in hands or feet, diabetic coma,		
activities of daily living (ADLs) such as eating, bathing,			insulin shock, or uncontrolled blood sugars?		
using the toilet independently, dressing, taking medications,			i. Emphysema, Chronic Obstructive Pulmonary Disease	_	_
or walking independently without the use of supportive			(COPD), or other chronic respiratory disorder (excluding		
devices?			mild asthma requiring occasional inhaler use)?		
·			29. During the past 24 months, has the Proposed Insured had		
Circle each condition resulting in a "Yes" answer for questions 27 through 29.			a suspended or revoked driver's license or had 3 or more		
· · · · · · · · · · · · · · · · · · ·			moving violations?		
27. During the past 12 months, has the Proposed Insured:					
a. Been admitted to or confined in a hospital two or more	_				
times?	Ц				
b. Been told by a medical professional that (s)he needs a					
medical procedure, surgery, hospitalization or nursing facility care that has not been completed?	_				
c. Been confined to a nursing facility or received home health	u				
care?					
vaic:	_	_			

For Home Office Endorsements:	Special Ins	tructions/Requests:			
AGREEMENT: I have read this application. I under nformation given in it is true, complete, and correctly condition of the Proposed Insured that are material to the contestable period. It is agreed that:	vritten. I understar	nd that any missta	atements as to t	he health	h or physical
A. This application, Part 2 of this application if applical Life as the basis of any policy which may be issue equivalent to the original.					
B. Acceptance of a policy issued on this application wi Endorsements." Written consent must be obtained					Home Office
C. Any policy issued by GPM Life, or applied for, sh is delivered to the owner during the lifetime of the application continue to be true and complete. The material change in health or other risk factors takin	e Proposed Insure Proposed Insure	ed, and all the st d and Owner/Ap	atements and a	answers	given in the
D. NO AGENT, BROKER OR MEDICAL EXAMINER IS TO MAKE OR MODIFY CONTRACTS, OR TO WAIN ONLY AN AUTHORIZED OFFICER OF GPM LIFE	/E ANY OF GPM L	IFE'S RIGHTS, C			
BACKUP WITHHOLDING CERTIFICATION: (require	ed to comply with	Federal tax law	): Under penalti	es of pe	erjury, I (the
proposed owner) certify that (A) my Social Security (and (B) I am not subject to backup withholding either withholding as a result of failure to report interest or dividending. (NOTE: You must cross out item B above backup withholding.)	Taxpayer Identification because I have no vidends, or the IRS	ation) number as t been notified by has notified me t	shown in the Apthe IRS that I ahat I am no long	pplication m subject er subject	n is correct, ct to backup ct to backup
AUTHORIZATION TO OBTAIN AND DISCLOSE I mental health facility, facility for the treatment of all medically related facility, employer, insurer, or its ago or law enforcement unit, consumer reporting agency mental or physical health, occupation, avocation, other give such information to GPM Life or its reinsurer(s) at except MIB, to give such information to any agent or Any information obtained will be used to determine a GPM Life to its reinsurer(s), the MIB, or other person with my application or claim, or as may be otherwise I the original. I also agree that this form will be valid for issuance, reinstatement, or change of an insurance possible authorized to act for me, may obtain a copy of this for "Medical Information Bureau, Inc." from GPM Life.  WARNING: Any person who knowingly and with the an application for insurance or settlement of claim	cohol, drug abuse ent, reinsurer, the control of the intent to defrat the intent to defrat the control of the c	e, or AIDS, Vete Medical Informate Se support organicer, habits, driving after my death. It organization achiece coverage an performing busing agree that a phote attention of a claim for receipt of notices and any insurance and any insurance Medical Information of a claim for the date signed attention of a claim for the da	ran's Administration Bureau, Incipation having in grecord, finance I further authoriting for GPM Lift denefits, and ness or legal serocopy of this for in connection with benefits. I known the entitled "Informer company, or	ation hose. (MIB), quantities of the content of the	spital, other government on as to the ge of me, to aid sources, reinsurer(s). released by connection as valid as eplication for or a person actices" and
purpose of misleading, information concerning ar					
is a crime and subjects such person to criminal a	nd civil penalties				
Proposed Insured's Signature X	Date	City & State Where	Application Comple	eted	
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where	Application Comple	eted	
AGENT'S STATEMENT: I HEREBY CERTIFY that the complete and true to the best of my knowledge and be Insured which is not fully set forth herein; that I carefut to the application being signed; that the Special Notice Inc. were given to the Proposed Insured. I further owitnessed the above signature(s): □ Photo ID verifie	elief; that I know of ully asked each ques regarding Inform certify that I have	no condition affeo estion as written nation Practices a	cting the insurab before recordin and the Medical	oility of th g each a Informat	ne Proposed answer prior tion Bureau,
, , , ,	,, <u> </u>	(REQUIRED)			
To the best of your knowledge:  A. Has the Proposed Insured any existing life insurar			١	∕es □	No □
B. Is the insurance applied for intended to replace or or annuity policy or contract?	change any existing	ng life insurance			
If the answer to A or B is "Yes", attach completed re	eplacement forms it	required by your			
X Writing Agent's Signature Date	Agent's Name (Plea	se Print)	State / License #	GPM Li	fe Agent #
	` '	•			

	RECEIPT FOR PAYMENT
Received from	Date
the sum of \$	The payment is received subject to the conditions below. This receipt does not provide any insurance.
I certify that I have explaine	all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.
Signature of Writi	Agent
ALL CHECK	MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY
application, if paid by take effect until the full the effective date of the	nless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the eck or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not rest premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, policy has arrived, and all the statements and answers given in the application continue to be true used Insured and Owner/Applicant must notify GPM Life of any material change in health or other before policy delivery.
TO MAKE OR MODIF	R MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

#### GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

#### **Government Personnel Mutual Life Insurance Company**

2211 N.E. Loop 410, San Antonio, Texas 78217

## PART 2 - CHILD INSURANCE RIDER SUPPLEMENTAL APPLICATION \$5,000 DEATH BENEFIT PER CHILD FOR CHILDREN OR GRANDCHILDREN OF PROPOSED INSURED

(Each Proposed Insured Child must reside in the household of the Proposed Insured.)

ISSUE AGES 15 DAYS – 17 YEARS INCLUSIVE

	PF	ROPOSED INSUR	ED CHILD'S		
Name (First, Mid		Date of Birth	Age Last Birthday	Relationship t	o Proposed Insured
treated for, tested positive circulatory disorder; cystic muscular dystrophy; sickle co mild asthma with occasional	fibrosis; kidney disea ell anemia; cerebral pa	ase; liver disease; alsy, cognitive or ps	diabetes; qua	driplegia; multiple s	sclerosis (MS); seizures;
And, in the past 24 months, substance except as prescril abuse or been convicted of a	bed by a medical pro	fessional. And, ha	ve not been co		
Remarks (please note the ch	ild's name and any ex	ceptions to the sta	itement above	).	
I, the Proposed Insured from of the Proposed Insured Chil true. I understand that all stal understand that the inform may result in coverage being become a part of any contra	d/Children and I have atements made by me ation on this applicati voided, subject to the ct of insurance issued	read the complete shall, in the absen on will be relied up e rider incontestab as a result of this	ed supplement ce of fraud, be con to determi ility provision. application.	al application. The ab deemed representat ne insurability and th agree that this supp ace – Part 1 was sign	pove representations are tions and not warranties. nat incorrect information lemental application will
Date Prin	t Name of Proposed In	sured from Part 1	Signat	ure of Proposed Insu	red from Part 1
Dute Filli	·			<u> </u>	Ca nomi alt I
Print Name	Signature	roposed Insured C	niid age 15 and nt Name	Signature	
				J.g.racar c	
Doto A	Nama (places wint)		hiting Assat/s C:	gnoture Ct-t	Olicopco # CDM Accet #
Date Agent's	s Name (please print)	V	/riting Agent's Si	gnature Stati	e/License # GPM Agent #

SM4CIR10 (0310)

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

## **Supporting Document Schedules**

Item Status: Status

Date:

Satisfied - Item: Flesch Certification

Comments: Attachments:

Readability Certification.pdf

Regulation 49.pdf

Rule and Regulation 19.pdf

Bulletin 15-2009.pdf

Item Status: Status

Date:

Satisfied - Item: Application

Comments:

Applications filed under Form Schedule Tab

Item Status: Status

Date:

Satisfied - Item: Red Line Version

Comments: Attachments:

Redline Comparions-SM420AR to SM420AR10.pdf

Redline Comparison-SM450AR to SM45MAR10.pdf

Item Status: Status

Date:

Satisfied - Item: Sample SPCB

Comments:

Attachment:

Printed Specimen SPCB - CIR.pdf

SERFF Tracking Number: GPML-126557922 State: Arkansas

Filing Company: Government Personnel Mutual Life Insurance State Tracking Number: 45490

Company

Company Tracking Number: 590 ADB10

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single

Life

Product Name: SM4/ADB/CIR applications

Project Name/Number: SM4/ADB/CIR applications/SM4/ADB/CIR applications

Item Status: Status

Date:

Satisfied - Item: Sample Schedule Page 3

Comments:

**Attachments:** 

Specimen SIWL Schedule Page 3 w ADB only.pdf

Specimen SIWL Schedule Page 3 w CIR only.pdf

Specimen SIWL Schedule Page 3 w ADB and CIR.pdf

ARKANSAS		
SUBJECT - Inc	dividual LifeX	Individual Annuity
INSURER - GOVE	ERNMENT PERSON	NEL MUTUAL LIFE INSURANCE COMPANY
FORM NUMBER		FLESCH SCORE
59O ADB10	52.	3
59P CIR10	60.	2
SM45M10	5	9 This form was scored as part of the policy with which it may be used.
SM42010	5	9 This form was scored as part of the policy with which it may be used.
SM4CIRA10	5	9 This form was scored as part of the policy with which it may be used.

This is to certify that the above referenced form has achieved a Flesch Reading Ease Score, as indicated, and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Sean Staggs, FSA, MAAA

ARKANSAS			
SUBJECT -	Individual Life	Х	Individual Annuity
INSURER - GOVERNMENT PERSONNE	EL MUTUAL LIFE INSU	IRANC!	E COMPANY

FORM NUMBER
590 ADB10

59P CIR10 SM45M10

SM42010 SM4CIRA10

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that the

company is in compliance with Regulation 49 in that we will issue a Life and Health notice to each policy owner.

Sean Staggs, FSA, MAAA

ARKANSAS			
SUBJECT -	Individual Life	X	Individual Annuity
INSURER - GOVERNMENT PERSONNE	EL MUTUAL LIFE INSU	IRANC	E COMPANY

FORM NUMBER

AR certification1

59O ADB10 59P CIR10 SM45M10 SM42010 SM4CIRA10

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.

Sean Staggs, FSA, MAAA

ARKANSAS				
SUBJECT -	Individual Life	x	Individual Annuity	
INSURER - GOVERNMENT PERSONNE	EL MUTHAL LIFE INSU	RANCE	COMPANY	
HOOKER - GOVERNMENT TERCONNE	DE MOTORIE EN ETITOO	IO II IO L		

59O ADB10 59P CIR10 SM45M10 SM42010 SM4CIRA10

FORM NUMBER

AR certification2

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that I have reviewed Bulletin 15-2009 and the form complies with these guidelines.

Sean Staggs, FSA, MAAA

# **Text Comparison**

Documents Compared SM420AR.pdf - Adobe Acrobat Professional

SM420AR10.pdf

## Summary

535 word(s) added

442 word(s) deleted

1925 word(s) matched

39 block(s) matched



## **APPLICATION FOR LIFE INSURANCE**

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

2211 N.E. LOOP 410, San Antonio, Texas 78217 Telephone: (800) 929-4765 (210) 357-2222

For Ages 20 through 49 Age Last Birthday

Mail Policy to:	
<b>⊟</b> Agent	
Policyholder	

www.gpmlife.com			
1.Name of Proposed Insured (First, M.I., Last)  2. Sex  3.Birthdate   4.Birthplace   5. US Citizen   6.Social Security #   7. Height   7.	8. W	/eight	
9. Home Address of Proposed Insured City State/Country Zip Telephone Number	<u></u>		
7. Home Madress of Froposed insured only State/Godinity Zip Telephone Maribo			
Best time to callA.MP.M. Time Zone: ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific	!		
10. Policy. 11. Amount 12. Premium 13. Premium Mode 14. Automatic Premi	<del>um Lo</del>	an	
□ SECURE-Mark 4 - WL Applied for: Amount □ Annual □ SemiAnnual (if available)			
\$ \$\\$ \\$ \\ \Delta \\ \De	10		
15. Beneficiary Social Security # Relationship Primary			
Contingent			
17. Owner/Applicant, if other than the Proposed Insured:			
Name Social Security # Relationship to Proposed Insured DOB _			
Address:			
18. Physician(s) name, address and phone number.			
19. a. List Life insurance in force on Proposed Insured: Company Issue Year ADB _			
	No		
	No		
If questions 21 through 29 are correctly answered "No", the Proposed Insured is eligible for SECURE-Mar	k 4	WI	
(Whole Life, Full Death Benefit).		***	
21. a. Are you currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home	VEC	МО	
health care, kidney dialysis, or oxygen?	<del></del>	₩ <b>=</b>	
b. Have you ever been diagnosed by a physician as having Congestive Heart Failure or Cardiomyopathy or been told	_	_	
you have less than 12 months to live?	<del></del>	=	
22. In the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired			
Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency			
Virus (HIV), or the antibodies to such virus?	$\blacksquare$	=	
23. Do you need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet independently;	_	_	
dressing, taking medications, or walking independently without the use of supportive devices?  24. During the past 24 months:			
a. Have you had a stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to			
the heart or brain?	<del></del>	=	
b. Have you had or been recommended to have an organ transplant?	$\blacksquare$	=	
c. Had or been treated (including medications or surgery) for melanoma, internal cancer, or leukemia?	$\blacksquare$	=	
25. During the past 24 months, have you had or been treated by a medical professional, including office visits, medications or surgery for	_	_	
a. Alzheimer's disease, dementia, or Parkinson's Disease?	<b>=</b>	<b>=</b>	
b. Emphysema, liver disease, kidney disease, or kidney failure? c. Alcohol and/or drug abuse?	=	<del></del>	
d: Diabetes requiring insulin or any diabetic complications including diabetic kidney disease, eye disorder, numbness in hands	_	_	
or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	<del>-</del>	<b>-</b>	
26. During the past 5 years, have you been convicted of a felony?	$\blacksquare$	$\blacksquare$	
Circle each condition resulting in a "Yes" answer for questions 27 through 29.			
27. During the past 12 months, have you:			
a. Been admitted to or confined in a hospital two or more times?	=	=	
<ul> <li>b. Been told by a medical professional that you need a medical procedure, surgery, hospitalization, or nursing facility eare?</li> <li>c. Been confined to a nursing facility or received home health care?</li> </ul>	=	=	
28. During the past 24 months, have you had or been treated by a medical professional, including office visits, medications or surgery for:		_	
a. Seizures or other neurological disorder, depression or other psychiatric disorder?	<b>-</b>	<b>=</b>	
b. Irregular heart rhythm, enlarged heart, or any other heart disorder?	<u>-</u>	<b>=</b>	
c. Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring			
occasional inhaler use)?		=	
d. Lupus (SLE), Muscular Dystrophy, Multiple Sclerosis, or other neuromuscular disorder?	=	=	
e. Diabetes requiring medication other than insulin?	<b>=</b>	=	
29. During the past 24 months, have you had a suspended or revoked driver's license or had 3 or more moving violations?		=	

APPLICATION FOR LIFE INSURANCE - Part 1
GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")
2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222 www.gpmlife.com For Ages 20 through 49, Age Last Birthday

Mail Policy to: Agent Policyholder

1.Name of Proposed Insured (First, M.I., Last)			
2. Sex ☐ Male ☐ Female 3 Birthdate			4 Birthplace
5 US Citizen    Yes			7. Height 8. Weight
9 Home Address of Proposed Insured City		State	/Country Zip Telephone Number
Rest time to call A.M. P.M.		Tir	ne Zone:     Eastern   Central   Mountain   Pacific
10 Policy: SECURE-Mark 4 - WL SECURE-Mark 4 - GI	)R I	11 A	mount Applied for \$ 12 Premium Amount \$
(WL Only) Accidental Death Renefit - ADR	-	13 P	remium Mode 🗖 Annual 14 Automatic Premium Loan
(WL Only) 1 \$5,000 Child Insurance Rider - CIR (Part 2 Require	<u>√h</u>		SemiAnnual □ Monthly FFT (if available) □ Yes □ No
15. Beneficiary			Security # Relationship 16 Proposed Insured's Occupation
15. Beneficiary Primary	50	ociai	Security # Relationship 10 Proposed instrems Octobalism
Contingent			
17. Owner/Applicant, if other than the Proposed Insured:			Deletionship to Drawcood Insured DOD
			Relationship to Proposed Insured DOB
Address:			
18. Physician(s) name_address and phone number:			
19. a. List Life insurance in force on Proposed Insured: Company			Issue Year ADB
b. Will the policy applied for replace or change any existing life			
20. Has the Proposed Insured used tobacco in any form in the pa			
If questions 21 through 28 are correctly answered "No" the			ed Insured may be eligible for SECLIRE-Mark 4 - WI (Whole Life Full
Death Renefit)			
21 a Is the Proposed Insured currently hospitalized, confined to a	YES	NO	
nursing home or hospice, receiving or been recommended			questions 26 through 28.
			26. During the past 12 months, has the Proposed Insured: YES NO.
b. Has the Proposed Insured ever been diagnosed by a physician			a. Been admitted to or confined in a hospital two or more
as having Congestive Heart Failure or Cardiomyopathy or			times?
been told (s)he has less than 12 months to live?			b. Been told by a medical professional that (s)he needs a
22 In the past 10 years has the Proposed Insured been			medical procedure, surgery, hospitalization, or nursing
diagnosed by or received treatment from a member of the			facility care that has not yet been completed?
medical profession for Acquired Immune Deficiency Syndrome			c. Been confined to a nursing facility or received home health
(AIDS); AIDS Related Complex (ARC); or tested positive for			care?
the Human Immunodeficiency Virus (HIV), or the antibodies to			27. During the past 24 months, has the Proposed Insured been
			treated or given medical advice by a medical professional,
23 Does the Proposed Insured need any assistance performing			including office visits, medications or surgery for:
activities of daily living (ADLs) such as eating, bathing, using			a. Seizures or other neurological disorder, Major Depression,
the toilet independently dressing, taking medications, or			Schizophrenia, Psychosis, Bipolar Disorder or other
walking independently without the use of supportive devices?			psychiatric disorder?
24 During the past 24 months, has the Proposed Insured heep			b. Irregular heart rhythm, enlarged heart, or any other heart
treated or given medical advice by a medical professional.			
ncluding office visits, medications or surgery for			disorder? \(\text{\textsup}\) c. Chronic Obstructive Pulmonary Disease (COPD), or
a. Stroke, transient ischemic attack (TIA), heart attack, angina,			other chronic respiratory disorder (excluding mild asthma
or any procedure to improve circulation to the heart or	_	_	requiring occasional inhaler use)?
			d. Lupus (SLE), Muscular Dystrophy, Multiple Sclerosis,
b Organ transplant or recommendation to have an organ	_	_	Amyotropic Lateral Sclerosis (ALS) or other neuromuscular
transplant?  c. Melanoma, internal cancer, or leukemia?	<u> </u>		disorder?
			e_Diabetes requiring medication other than insulin?
d. Alzheimer's disease, dementia, Amyotropic Lateral Sclerosis	_	_	28 During the past 24 months, has the Proposed Insured had
<b>1</b>	П		a suspended or revoked driver's license or had 3 or more
€ Emphysema, liver disease, kidney disease, or kidney			moving violations?
failure?			
	4		
g. Diabetes requiring insulin or any diabetic complications			
including diabetic kidney disease, eye disorder, numbness in			
hands or feet, diabetic coma, insulin shock, or uncontrolled	_	_	
blood sugars?			
25. During the past 5 years, has the Proposed insured been			
convicted of a felony, been incarcerated, or been on parole or		_	
probation for any offense?	<u> </u>	Д	

		Special Ins	structions/Requests:		
AGREEMENT: I have read this information given in it is true, comcondition of the Proposed Insure the contestable and suicide perio	plete, and correctly did that are material to	written. I understa	nd that any misstatements	as to the	health or ph
A. This application and any amer may be issued. The signer(s) a	ndments or supplem				
B. Acceptance of a policy issued Endorsements." Written conse					
C. Any policy issued by GPM Li is delivered to the owner duri application continue to be true Proposed Insured) knowledge	ng the lifetime of the and <del>complete to the</del>	e Proposed Insure e best of the Prop	ed, and all the statements osed Insured's and Owner	and ansv r's/Applica	wers given ant's (if othe
change in health or other risk f				ily Of IVI E	iic or arry rin
D. NO AGENT, BROKER OR ME TO MAKE OR MODIFY CONTE ONLY AN AUTHORIZED OFFI	RACTS, OR TO WAI	VE ANY OF GPM L	IFE'S RIGHTS, CONDITIC		
proposed owner) certify that (A) and (B) I am not subject to backuwithholding as a result of failure to withholding. (NOTE: You must obackup withholding.)	my Social Security up withholding either or report interest or di	(Taxpayer Identific because I have no vidends, or the IRS	ation) number as shown in of been notified by the IRS Is has notified me that I am i	the Appli that I am s no longer s	ication is co subject to ba subject to ba
information to GPM Life or its re MIB, to give such information to information obtained will be used Life to its reinsurer(s), the MIB, my application or claim, or as ma original. I also agree that this for issuance, reinstatement, or change	o any agent or insured to determine eligible or other persons or any be otherwise lawform will be valid for (1)	ance support organity for insurance of organizations perfully required. I agree to the second of the support of	anization acting for GPM Leoverage and benefits, and orming business or legal see that a photocopy of this the date signed in connectation of a claim for benefits	ife or its and may be reservices in form will be to the controll of the control o	reinsurer(s) released by a connection be as valid a an application
authorized to act for me, may ob	tain a copy of this fo	rm. I acknowledge	receipt of notices entitled	"Information	that I, or a pe on Practices
authorized to act for me, may ob "Medical Information Bureau, Inc	tain a copy of this fo c." from GPM Life.			"Information	on Practices
authorized to act for me, may ob	tain a copy of this fo c." from GPM Life. nowingly and with to or settlement of cla	he intent to defra	ud any insurance compa y materially false informa	"Information any, or other	on Practices her person, onceals, fo
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For Home Utilice Engorsements:	Special Instructions/Requests:

**AGREEMENT:** I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

- A This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.
- B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.
- C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.
- D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A OFNITIC CTATEMENT, I LIEDEDY CEDTLEY that the		the females acceptions in this confication are full
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed
X		
Proposed Insured's Signature	Date	City & State Where Application Completed

**AGENT'S STATEMENT: I HEREBY CERTIFY** that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed

,	,	arefully asked each question as wr lotices regarding Information Practi		_		
	ed Insured. I furth	er certify that I have interviewed				
		(REQUIRE	D)			
To the best of your knowledge:			, ·	⁄es	No	
A. Has the Proposed Insured a	ny existing life ins	urance or annuity policy or contrac	t?		$\Box$	
B. Is the insurance applied for i	ntended to replac	e or change any existing life insura	ince			
or annuity policy or contract	?			$\Box$	$\Box$	
If the answer to A or B is "Yes	s", attach complete	ed replacement forms if required by	your state.			
Χ						
Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPN	1 Life Agent #	
2144004 D40		(D 0 (0)			/004	$\overline{}$

RECEIPT FOR PAYMENT
Received from Date
the sum of \$ The payment is received subject to the conditions below. This receipt does not provide any insurance.
I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.
Signature of Writing Agent
ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY
This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.
NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

#### GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY - San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

Date
The payment is received subject to the conditions below. This receipt does not provide any insurance.
terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.
_

#### ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

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#### GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY & San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

# **Text Comparison**

Documents Compared SM450AR.pdf - Adobe Acrobat Professional

SM45MAR10.pdf

## Summary

606 word(s) added 449 word(s) deleted

1853 word(s) matched

32 block(s) matched



# APPLICATION FOR LIFE INSURANCE GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("CPM Life") 2211 N.E. LOOP 410, San Antonio, Texas 78217 Telephone: (000) 929 4765 (210) 357-2222 Telephone: (000) 929 4765 (210) 357-2222 Telephone: (000) 929 4765 (210) 357-2222

## For Ages 50 through 85 Age Last Birthday

Mail Policy to:
<b>B</b> Agent
<b>□</b> Policyholder

VV VV	<del>v.gpmlife.com</del>		•	or Ages	00 111104	gii oo, Aş	je Last Di	tilday			
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<del>9. H</del>	ome Address of Propose	<del>d Insured</del>	City	State/	 <del>'Country</del>	Zip		<del>Telepho</del>	ne Numb	 <del>CT</del>	
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<del>22.</del>	In the past 10 years, hav	<del>e you</del> been diagnos	sed by or rece	ived treatmer	nt from a mem	ber of the med	dical profession	for Acquire	d		
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	cle each condition resul	•		•					•	_	_
	During the past 12 month	•	swei ioi ques	500113 23 011	ough 27.						
20.	a. Been admitted to o		oital two or mo	re times?						<b>_</b>	<b>-</b>
	b. Been told by a med				cedure, suraer	v. hospitalizati	on or nursina fa	acility <del>care?</del>	Į.	_ <b>글</b>	<del>-</del>
	c. Been confined to a	-	-	-	-	J,	J	· · · · · · · · · · · · · · · · · · ·		<b>→</b>	<del></del>
<del>26.</del>	During the past 24 month					including offic	e visits, medica	tions or sur	gery for:		
	a. Stroke, transient is	-		-	-	-				<b>→</b>	$\blacksquare$
	b. Organ transplant, o	or recommendation	to have an org	gan transplar	t?				<del>(</del>	<b>→</b>	
	c. Melanoma, interna	l cancer, or leukemi	<del>a?</del>						ŧ	<b>→</b>	
	d. Parkinson's Diseas	<del>se, seizure, neurolo</del> g	jical disorder,	depression d	r other psychi	atric disorder?	1		ŧ	<b>→</b>	$\blacksquare$
	e. Liver disease, kidn	ey disease, kidney l	failure or Lupu	is (SLE)?					<del>(</del>	<b>→</b>	
	f. Irregular heart rhyt	hm, enlarged heart,	or any other I	neart disorde	r?					<b>→</b>	<del>-</del>
	g. Alcohol and/or drug	-							•	<b>→</b>	=
	h. Diabetes requiring							ase,	-	_	
	•	oness in hands or fe					•		ŧ	<b>=</b>	=
	i. Emphysema, Chro		•	se (COPD), o	r otner chronic	c respiratory d	isoraer (excludi	ng mila	1	_	<b>=</b>
27	astrilla requiring of During the past 24 month	ccasional inhaler us	-	revoked driv	er's license or	had 3 or more	movina violeti	nns?		<b>=</b> <b>→</b>	<u></u>
۷,		13, Have you had a	ouspenueu U			nau J UI IIIUI t	Thorning violatil	U113 i		<b>-</b>	
O	FOAD			<b>/</b> D	4 (0)						/\ n =

APPLICATION FOR LIFE INSURANCE - Part 1
GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")
2211 N F I OOP 410 San Antonio Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222 For Ages 50 through 85, Age Last Birthday www.apmlife.com

Mail Policy to:	
☐ Agent	
Policyholder	

1.Name of Proposed Insured (First, M.I., La									
	<u>irthdate</u>				Rirthplace				
5 US Citizen ☐ Yes ☐ No 6.So	ocial Security #				. Height	8. Wei	ght		
9 Home Address of Proposed Insured	City	State	<u>/Country</u>	<u>Z</u>	<del>ip</del>	Teleph	one Num	<u>her</u>	
Rest time to call A M	<u>PM</u>			Eastern	☐ Central			<u>c</u>	
	SECURE-Mark 4 - GDR	11 Aı	mount Applied	l for·\$		12 Premium Amo	unt: \$		
SECURE-Mark 4 - MBWL (WL Only) Accidental Death Renefit - A	,DR	13 P	remium Mode	□ Annual	ı	14 Automatic Pre	mium Lo:	an	
WL Only D \$5,000 Child Insurance Ride	er - CIR (Part 2 Required)	1	☐ SemiAnnua	l 🔲 Moi	nthly FFT	(if available) 🖵 Y	es 🗆	<u>No</u>	
15 Reneficiary	, , ,		Security #	R	elationshin	16 Proposed Ins	ured's Oc	cupation	1
Primary					'	'			
Contingent									
17. Owner/Applicant, if other than the Propo	osed Insured:								
Name			Relation	nship to Pr	oposed Insu	red	DOB		
Address:					-				
18 Physician(s) name address and phone	numhar								
J , , ,					Janua Van	_	ADD		
19. a. List Life insurance in force on Propo	sea insurea: Company	! !			_ issue yea				
h Will the policy applied for replace or c				ract in any	company?				
20 Has the Proposed Insured used tobacc If questions 21 through 29 are correct	to in any form in the past i	12 mon	ILIUS!	ما ام ما ام	ible for CE	CUDE Morle 4 M	Yes [	No.	FII
Death Benefit)	y answeren inn ine er	ropose	an insulan m	iay be elig	IDIA IDI ZE	L.HRF-Mark 4 - V	vi (vvnoi	e i lie i	-11111
Dealt Belletti,	\/F	-0. N/O	. 1						NO
		S NO						YFS	NO
21 Is the Proposed Insured currently hos			-	- 1		s the Proposed In			
nursing home or hospice, receiving of				0		😉 by a medical p		al,	
to receive home health care or kid						ons or surgery for			
diagnosed by a physician as having						attack (TIA), he			
dementia_or_Amyotropic_Lateral_Sclero						to improve circula			
(s)he have less than 12 months to live									
22 In the past 10 years, has the Pro	· ·					mendation to hav			
diagnosed by or received treatmen			trans	plant?		or leukemia?			
the medical profession for Acquired									
Syndrome (AIDS); AIDS Related Com			· ·			<u>e, neurological dis</u>		_	
positive for the Human Immunodeficie			Depre	ession Sc	nizophrenia,	Psychosis Ripol	ar Disorde	<u>er,</u> _	_
antibodies to such virus?						?			
23 During the past 5 years, has the Pi						<u>e_kidney failure_l</u>			_
convicted of a felony, been incarcerate	<u> </u>		or An	nyotropic L	ateral Sclerd	nsis (ALS)?			
prohation for any offense?						rged heart, or any	other hea	art	_
24 Is the Proposed Insured currently	y receiving or heen			der?					<u> </u>
recommended to receive oxygen?			J		lrug ahuse?				Ц
25 Has the Proposed Insured ever heen dis					•	an 80 units of ins		•	
as having Congestive Heart Failure or						ıding diabetic kidn			
26 Does the Proposed Insured need any						hands or feet, dia			
activities of daily living (ADLs) such						d blood sugars?_			
using the toilet independently, dressin						structive Pulmona			
or walking independently without the						espiratory disorde			
devices?						sional inhaler use)			
Circle each condition resulting i	n a "Yes" answer		0			as the Proposed I			
for questions 27 throu						er's license or had			_
27 During the past 12 months, has the Pro	onocod Incurad:		moving	violations?					Ц
a. Been admitted to or confined in a									
times?		а п							
b. Been told by a medical profession									
medical procedure, surgery, hosp									
facility care that has not been comp		а 🗖							
c. Been confined to a nursing facility of									
care?	i receiveu nonie nedili F								
Care:									

AGREEMENT: I have read this application. I understand the questions and my answers, and I reginformation given in it is true, complete, and correctly written. I understand that any misstatements as to condition of the Proposed Insured that are material to the risk assumed may cause any policy issued the contestable and society period. It is agreed that.  A This application and any amendments or supplements to it will be relied on by GPM Life as the bas may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the se Endorsements." Written consent must be obtained for any change in the application, where required C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and application continue to be true and complete to the best of the Proposed Insured and Owner's Appropriate to other risk factors taking place before policy delivery.  D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS I TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, only AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.  BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under pena proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no to my administration of the pass o	sts:	/Requests:	Spe		for Home Office Endorsements:
information given in it is true, complete, and correctly written. I understand that any misstatements as to condition of the Proposed Insured that are material to the risk assumed may cause any policy issued he contestable and saicide period. It is agreed that:  **No septication and any amendments or supplements to it will be relied on by GPM Life as the bas may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the discovered to the contest of the proposed insured. Acceptance of a policy issued on this application will ratify any changes which may be noted in the se Endorsements. Written consent must be obtained for any change in the application, where required a complete to the owner during the lifetime of the Proposed Insured, and all the statements and application continue to be true and complete to the best of the Proposed Insured, and all the statements and application continue to be true and complete to the best of the Proposed Insured, and all the statements and application continue to be true and complete to the best of the Proposed Insured. And Owner Applicant must notify GP change in health or other risk factors taking place before policy delivery.  **DN OAGENT, BROKER OR MEDICAL EXAMINER IS SAUTHORIZED TO ACCEPT RISKS OR PASS IN TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS (**ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.**  **BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under pena proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the mortification of the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the mortification of the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the mortification of the proposed owner) certify that (**DR TAY AUTHORIZED OFFICER OFFIC					
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Endorsements." Written consent must be obtained for any change in the application, where required it. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and application continue to be true and complete to the best of the Proposed Insured and Owner/Applicant must notify GF change in health or other risk factors taking place before policy delivery.  NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS I TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.  BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under pena proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the land (B) I am not subject to backup withholding either because I have not been notified by the IRS that I withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no lor withholding.) (NOTE: You must cross out item B above if you have been notified by the IRS that you a backup withholding.)  AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practite metal health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administ medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, in or law enforcement unit, consumer reporting agency, or other insurance support organization having mental or physical health, occupation, avocation, other insurance support organization brains medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, inc. I was application or claim, or as may avocation, other insurance support organization brains medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, inc. I was appli					
is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and application continue to be true and complete to the best of the Proposed Insured's and Owner's/Application continue to be true and complete to the best of the Proposed Insured's and Owner's/Application continue to be true and complete to the best of the Proposed Insured's and Owner/Applicant must notify GP change in health or other risk factors taking place before policy delivery.  D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS IS TO MAKE OR MODIFY CONTRACTS, ORTO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.  BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under pena proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you a backup withholding.) (NOTE: You must cross out item B above if you have been notified by the IRS that you a backup withholding.)  AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practit mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Adminismedically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Ir or law enforcement unit, consumer reporting agency, or other insurance support organization having mental or physical health, occupation, avocation, other insurance, character, habits, driving record, fina give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further auth sexcept MIB, to give such information to any agency, or other insurance support organization acting for GPM I Any information obtained will be used to determine eligibility for insurance coverage and benefits, and					
D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS OF TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF 69M LIFE'S RIGHTS, CONDITIONS, ONLY AN AUTHORIZED OFFICER OF 6PM LIFE CAN DO THESE THINGS.  BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under pena proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I and (B) I am not subject to backup withholding either because I have not been notified by the IRS that you a backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you a backup withholding.)  AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practit mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administ medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, In or law enforcement unit, consumer reporting agency, or other insurance, character, habits, driving record, fina give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further auth except MIB, to give such information to any agent or insurance support organization acting for GPM I Any information obtained will be used to determine eligibility for insurance coverage and benefits, and GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legals with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this fithe original. I also agree that this form will be valid for (1) 30 months from the date signed in connection issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. It with the original is a crime and subjects su	e statements and answers and Owner's/Applicant	all the statements and answers given in t sured's and Owner's/Applicant's (if other th	Proposed I best of the ed Insured	r during the lifetime of the e true and <del>complete to the edge and belief.</del> The Propo	is delivered to the owner application continue to be Proposed Insured) knowledge of the continue to be proposed Insured.
proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no lor withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you a backup withholding.)  AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitimental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administ medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, In or law enforcement unit, consumer reporting agency, or other insurance support organization having mental or physical health, occupation, avocation, other insurance, character, habits, driving record, fina give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authexcept MIB, to give such information to any agent or insurance support organization acting for GPM I have information obtained will be used to determine eligibility for insurance coverage and benefits, and GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal s with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this five original. I also agree that this form will be valid for (1) 90 months from the date signed in connection issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I knauthorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Infor "Medical Information Bureau, Inc." from GPM Life.  WARNING: Any person who knowingly and with the intent to defraud any insurance company, can application for insurance or settlement of claim containing any materially false information purpose of misleading, in		IGHTS, CONDITIONS, OR REQUIREMENT	AUTHORIZ ANY OF G	R MEDICAL EXAMINER IS ONTRACTS, OR TO WAIV	D. NO AGENT, BROKER OI TO MAKE OR MODIFY C
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitemental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administ medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, it or law enforcement unit, consumer reporting agency, or other insurance support organization having mental or physical health, occupation, avocation, other insurance, character, habits, driving record, final give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further auth except MIB, to give such information to any agent or insurance support organization acting for GPM I any information obtained will be used to determine eligibility for insurance coverage and benefits, and GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal swith my application or claim, or as may be otherwise lawfully required. I agree that that a photocopy of this five original. I also agree that this form will be valid for (1) 39 months from the date signed in connection assuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I knauthorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Eureau, Inc." from GPM Life.  WARNING: Any person who knowingly and with the intent to defraud any insurance company, or an application for insurance or settlement of claim containing any materially false information burpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance and subjects such person to criminal and civil penalties.  WARNING: STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in the complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurance supposed Insured to the Proposed Insured. I further certify that I have interviewed the Proposed Insured t	r as shown in the Applica d by the IRS that I am sul me that I am no longer su	umber as shown in the Application is correct motified by the IRS that I am subject to back tified me that I am no longer subject to back	xpayer Ide cause I ha lends, or th	at (A) my Social Security (T backup withholding either b ilure to report interest or divi	oroposed owner) certify that and (B) I am not subject to l withholding as a result of fai withholding. (NOTE: You m
Date City & State Where Application Composed Insured's Signature (If other than Proposed Insured's Proposed Insured's Signature (If other than Proposed Insured)  AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in the complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurance on the application being signed; that the Special Notices regarding Information Practices and the Medica not. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured witnessed the above signature(s):  Photo ID verified Type of ID  To the best of your knowledge:	rmation Bureau, Inc. (MIE ganization having inform driving record, finances, cath. I further authorize an acting for GPM Life or and benefits, and may business or legal services photocopy of this form will ned in connection with an m for benefits. I know that ices entitled "Information rance company, or othe	al Information Bureau, Inc. (MIB), government or organization having information as to the bits, driving record, finances, or age of me, my death. I further authorize all said source ization acting for GPM Life or its reinsurer (serage and benefits, and may be released liming business or legal services in connection hat a photocopy of this form will be as valid at the signed in connection with an application of a claim for benefits. I know that I, or a person of notices entitled "Information Practices" are insurance company, or other person, file	t, reinsurer or other insurance, ny time, incompanies or organizate of the control of the contro	mployer, insurer, or its age consumer reporting agency, occupation, avocation, other PM Life or its reinsurer(s) at a formation to any agent or it will be used to determine ele, the MIB, or other persons a, or as may be otherwise lat this form will be valid for (change of an insurance polary obtain a copy of this form au, Inc." from GPM Life.  ho knowingly and with the	medically related facility, er or law enforcement unit, comental or physical health, of give such information to GP except MIB, to give such in Any information obtained was GPM Life to its reinsurer(s) with my application or claim the original. I also agree that ssuance, reinstatement, or authorized to act for me, mand Medical Information Bureat WARNING: Any person was
Owner's/Applicant's Signature (If other than Proposed Insured)  AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in the complete and true to the best of my knowledge and belief; that I know of no condition affecting the insural Insured which is not fully set forth herein; that I carefully asked each question as written before record to the application being signed; that the Special Notices regarding Information Practices and the Medical Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured witnessed the above signature(s):  Photo ID verified Type of ID  To the best of your knowledge:	ts a fraudulent insuranc	ommits a fraudulent insurance act, which	act materi	formation concerning any	purpose of misleading, inf a crime and subjects such
AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in the complete and true to the best of my knowledge and belief; that I know of no condition affecting the insural Insured which is not fully set forth herein; that I carefully asked each question as written before record to the application being signed; that the Special Notices regarding Information Practices and the Medical Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insureds witnessed the above signature(s): Photo ID verified Type of ID  To the best of your knowledge:	here Application Completed	State Where Application Completed	Date		
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To the best of your knowledge:	affecting the insurability of tten before recording each ces and the Medical Inform	dition affecting the insurability of the Propose as written before recording each answer pri Practices and the Medical Information Burea	ef; that I kn y asked ea regarding ertify that I	st of my knowledge and bel et forth herein; that I carefu ned; that the Special Notice posed Insured. I further c	complete and true to the be Insured which is not fully se to the application being sigr Inc. were given to the Prop
A Has the Proposed Incured any existing life incurance or appuity policy or contract?	Yes			•	
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?		nsurance		for intended to replace or o	B. Is the insurance applied

Agent's Name (Please Print)

Date

Writing Agent's Signature

State / License # GPM Life Agent #

**AGREEMENT:** I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

- A This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.
- B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.
- C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.
- D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Duana a a al luca una alta Ciana abuna

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full,						
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed				
X		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				
Proposed insured's Signature	Date	City & State where Application Completed				

City O Chata Milana Annii antina Cananinta d

complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed

			arefully asked each question as writotices regarding Information Practic				
Inc.	were given to the Proposed	Insured. I furth	er certify that I have interviewed the	he Proposed Insur	ed fac	ce to face an	10
witn	essed the above signature(s):	☐ Photo ID ve	erified Type of ID	•			
	3 ( )		(REQUIRE	<u>)</u>			
To th	ne best of your knowledge:		`	•	Yes	No	
A. H	las the Proposed Insured any	existing life ins	urance or annuity policy or contract	?	$\Box$		
B. Is	s the insurance applied for inte	ended to replace	e or change any existing life insurar	nce			
0	r annuity policy or contract?	·	5 , 5		$\Box$		
lf	the answer to A or B is "Yes",	attach complete	ed replacement forms if required by y	your state.			
Χ				1			
	Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPN	/I Life Agent #	_
							_

	RECEIPT FOR PAYMENT	
Received from		Date
the sum of \$	. The payment is received subject to the conditions below.	This receipt does not provide any insurance.
I certify that I have explained all of the	terms of this receipt to the Owner(s)/Applicant(s), and Propo	osed Insured, if different.
Signature of Writing Agent		

#### ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

#### GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY - San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

	Date
e payment is received subject to the conditions below.	This receipt does not provide any insurance.
s of this receipt to the Owner(s)/Applicant(s), and Propos	sed Insured, if different.
	s of this receipt to the Owner(s)/Applicant(s), and Propos

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#### GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY & San Antonio, Texas 78265

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Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

## STATEMENT OF POLICY COST AND BENEFIT INFORMATION - POLICY SUMMARY

Child Insurance Rider

Specimen Copy

Insured on Rider:

John L Doe

**Policy Number:** 

000970006

Initial Sum Insured:

\$5,000.00

**Rider Effective Date:** 

January 1, 2010

State:

TX

\$1.32 MONTHLY

5,000

5,000

5,000

5,000

5,000

5,000

5,000

Issue Age:

Risk Class:

4 MALE

**Initial Annual Premium:** 

15

16

17

18

19

20

21

19

20

21

22

23

24

25

\$15.00

Plan Code:

CIR10S 100%

------ANNIVERSARY--**DEATH BENEFIT** END OF AΤ IN AΤ YEAR AGE YEAR START OF YEAR 1 5 \$5,000 2011 2 6 2012 5,000 3 7 2013 5,000 4 8 2014 5,000 5 5,000 9 2015 6 10 5,000 2016 7 5,000 11 2017 8 5,000 12 2018 9 5,000 13 2019 10 5,000 14 2020 11 5,000 15 2021 12 2022 5,000 16 13 5,000 17 2023 14 2024 5,000 18

2025

2026

2027

2028

2029

2030

2031

GUARANTEEI ANNUAL PREMIUM
15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00

This statement provides general information about the optional rider identified above. For similar information about the basic plan, optional riders or supplemental benefits of the policy, refer to attached statements. Refer to provisions of the policy for answers to specific questions regarding premiums, benefits, and options.

Continued on back of page

THIS IS AN ILLUSTRATION ONLY. AN ILLUSTRATION IS NOT INTENDED TO PREDICT ACTUAL PERFORMANCE. INTEREST RATES, DIVIDENDS, VALUES SET FORTH IN THE ILLUSTRATION ARE NOT GUARANTEED EXCEPT FOR THOSE ITEMS CLEARLY LABELED AS GUARANTEED.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY GPM LIFE BUILDING, 2211 N.E. LOOP 410, P. O. BOX 659567, SAN ANTONIO, TEXAS 78265-9567 RiderPS SM2010 1-800-929-4765

Prepared on:

1/14/2010

## STATEMENT OF POLICY COST AND BENEFIT INFORMATION - POLICY SUMMARY

**Child Insurance Rider** 

	INSURANCE COVERAGE	INSURED	AGE	INITIAL BENEFIT AMOUNT	INITIAL ANNUAL PREMIUM
CIR10S	Child Insurance Rider	John L Doe	4	5,000	15.00

Life Insurance Interest Adjusted Cost Comparison Indexes per \$1,000 (Assumes that the time value of money is 5% per year):

	Guaranteed			
	10 Year	20 Year		
	\$ 3.00	\$ 3.00		
Surrender Cost Comparison Index	3.00	3.00		
Net Payment Cost Comparison Index	N/A	N/A		
Fauivalent Level Annual Dividend	•	•		

An explanation of the intended use of these indexes is included in the Life Insurance Buyers Guide.

Any Questions -- Please contact your agent or the Home Office.

Agent:

00025

Home Office

PO Box 659567

San Antonio TX 78265-9567

Phone:

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY GPM LIFE BUILDING, 2211 N.E. LOOP 410, P.O. BOX 659567, SAN ANTONIO, TEXAS 78265-9567

1-800-929-4765 RiderPS SM2010

Page 2 of 2

Prepared on: 1/14/2010

000970006

## **SCHEDULE PAGE**

PLAN	COVERAGE DESCRIPTION	INITIAL SUM INSURED		ANNUAL BENEFIT PREMIUM CEASES	POLICY NUMBER:
SIWL07	Simplified Issue Whole Life	\$25,000	100%		000970007
ADB10S	Insurance Policy Accidental Death Benefit Rider	al Death \$25,000	100% \$35.25	<b>\$35.25</b> 2045	POLICY DATE: January 1, 2010
					NAME OF INSURED:
					John Doe
					AGE AT ISSUE/SEX:
					35 MALE ANNUAL PREMIUM:
					\$440.25
					Semi-Annual Premium \$233.43
					Special Monthly \$38.60
					Electronic Funds Transfe \$38.60 Monthly
					OWNER John Doe
					·
	·				The owner and beneficiary are as stated in the application unless later changed.

## **SCHEDULE PAGE**

PLAN	COVERAGE DESCRIPTION	INITIAL SUM INSURED	POLICY CLASS	ANNUAL PREMIUM	POLICY NUMBER:
SIWL07	Simplified Issue Whole Life	\$25,000		\$405.00 rd No Tobac	000970008  POLICY DATE:
CIR10S	Insurance Policy Child Insurance Rider Insured: John L Doe	\$5,000 rance Rider	100% \$15.00 <sup>2031</sup> Male 04		January 1, 2010  NAME OF INSURED:
					John Doe  AGE AT ISSUE/SEX:
					35 MALE ANNUAL PREMIUM:
					\$420.00
					Semi-Annual Premium \$222.70
					Special Monthly \$36.82
					Electronic Funds Transfer \$36.82 Monthly
				,	OWNER John Doe
					-
					The owner and beneficiary are as stated in the application unless later changed.

### **SCHEDULE PAGE**

Specimen Simplified Issue Whole Life Schedule Page with Accidental Death Benefit Rider and Child Insurance Rider.

COVERAGE DESCRIPTION	INITIAL SUM INSURED	POLICY CLASS	ANNUAL B	
Simplified Issue	\$25,000	100%	\$405.00	2075
Whole Life	Standard No Tobacco			
Insurance Policy Accidental Death	\$25,000	100%	\$35.25	2045
Benefit Rider				
Child	\$5,000	100%	\$15.00	2031
Insurance Rider		- 10	Male 04	
	DESCRIPTION Simplified Issue Whole Life Insurance Policy Accidental Death Benefit Rider Child Insurance Rider	COVERAGE SUM INSURED  Simplified Issue \$25,000 Whole Life Insurance Policy Accidental Death Benefit Rider  Child \$5,000 Insurance Rider	COVERAGE DESCRIPTION INSURED CLASS  Simplified Issue \$25,000 100% Standar Insurance Policy Accidental Death Benefit Rider Child \$5,000 100% Insurance Rider	COVERAGE DESCRIPTION INSURED CLASS PREMIUM CLASS PREMIUM CLASS PREMIUM CLASS PREMIUM CSIMPLIFIED STANDARD NO TODACCION CONTROL

POLICY NUMBER:

000970006

POLICY DATE:

January 1, 2010

NAME OF INSURED:

John Doe

AGE AT ISSUE/SEX:

35 MALE

ANNUAL PREMIUM:

\$455.25

Semi-Annual Premium \$241.38

Special Monthly \$39.92

Electronic Funds Transfer \$39.92 Monthly

OWNER
John Doe

The owner and beneficiary are as stated in the application unless later changed.